



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Patient Care and Mismanagement Issues VA Medical Center West Palm Beach, Florida

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: **Final Report** – Healthcare and Audit Inspection – Patient Care and Mismanagement Issues, VA Medical Center, West Palm Beach, Florida
Project Number: 2004-02051-HI-0355

Purpose

The VA Office of Inspector General (OIG), Offices of Healthcare Inspections (OHI) and Audit, reviewed allegations related to quality of patient care, prohibited personnel practices, and mismanagement made by various constituents of the office of Congressman Alcee L. Hastings. The purpose of the review was to determine whether the allegations had merit.

Background

The VA Medical Center located in West Palm Beach, Florida, is a tertiary care hospital that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community-based clinics located in Boca Raton, Delray Beach, Fort Pierce, Okeechobee, Stuart, and Vero Beach. The medical center is part of Veterans Integrated Service Network (VISN) 8 and serves a veteran population of about 275,000 in a primary service area that includes seven Florida counties.

Congressman Hastings asked the Office of Inspector General to ascertain whether:

- Delays in scheduling Magnetic Resonance Imaging (MRI) tests caused patients to suffer adverse events, MRIs were outsourced, and excessive overtime was used.
- Wound care services were discontinued and community based outpatient clinic (CBOC) employees lacked wound care training, which resulted in negligent care, gangrene, and amputations.
- Homeless veterans were denied Emergency Room care.
- Unnecessary lodging was provided to 70 administrative staff for a retreat.

- The new telephone system did not work properly, and patients were unable to contact the medical center to make appointments.
- A contract in excess of \$750,000 was awarded to a personal friend of the Director.
- An employee was promoted inappropriately.
- Service Chiefs hired or supervised family members.

Allegations related to the manipulation of appointment schedules were also reviewed and will be addressed in a separate report.

Scope and Methodology

In performing the review, we inspected work areas and interviewed managers and other employees knowledgeable about the topics discussed. We reviewed quality management and administrative records, and examined medical records of select patients. We also reviewed facility contracts and Human Resource Management Services (HRMS) files. We reviewed facility and VHA policies, procedures, and standards related to the above issues.

The inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Quality of Care

Allegation A: Hundreds of MRI (Magnetic Resonance Imaging) requests remained pending in a clerk's desk while veterans were not scheduled for diagnostic tests. As a result, some veterans died, MRIs were outsourced, and excessive overtime was used.

Findings

Summary

Imaging Service managers did not effectively monitor and process pending workload, which resulted in unacceptable scheduling delays for several imaging modalities. However, we found no evidence that veterans died because of these delays. In addition, while Imaging Service did utilize outsourcing and overtime to process some MRI exams, we found these to be necessary and reasonable steps to eliminate the backlog of exams.

Background

The Imaging Service offers Computer Tomography (CT), MRI, Ultrasound, Angiography and Interventional Procedures, general x-rays, and Nuclear Medicine exams. The medical center did not have established time frames for scheduling appointments or interpreting images; however, STAT (emergent) requests generally require examination and interpretation immediately. Urgent requests, while not life-threatening, require examination and interpretation within 1 day. In accordance with VISN standards on clinic access, routine requests require examination within 30 days, and image interpretation and verification within 4 days¹ of exam completion.

Allegation A-1: Hundreds of MRI requests remained pending in a clerk's desk while veterans were not scheduled for diagnostic tests.

The allegation was partially substantiated. We verified the allegation that hundreds of MRI requests were delayed, and determined that CT, Ultrasound, and Stress Thallium tests were backlogged. However, we did not confirm that the MRI exams were not scheduled because they remained pending in a clerk's desk drawer. We could not confirm this part of the allegation because witnesses provided different accounts as to how and where the pending MRI requests were discovered. Two witnesses reported that they found 143 CT requests (not MRIs) in a drawer but were unable to provide the patients' names or dates of the requests. A third witness reported that she was unaware of requests being found in a clerk's drawer but stated that backlogged imaging requests

¹ FY 2004 VHA Performance Measure 16, dated November 26, 2003

were kept on clipboards in the scheduling office. A fourth witness reported being shown a batch of backlogged imaging requests and estimated the batch of paper requests to be about six inches thick.

Scheduling Backlogs

Our review of CT and MRI exams showed that, from April 2002 to May 2004, 2,977 (2,026 CT and 951 MRI) tests were not scheduled within 30 days, as required, with one request dating back to April 2002. The Chief, Imaging Service (CIS) stated that he became aware of the processing delays in early March 2004 after reviewing a report of patients who were currently waiting longer than 30 days for imaging exams. The CIS stated that he and another radiologist triaged the pending requests to ensure that patients with priority needs received prompt evaluations.

To reduce the backlog, Imaging Service managers authorized the outsourcing of imaging exams, and assigned Medical Administration Service employees to contact patients and arrange for fee-based services. As shown in the table, the backlog of patients waiting longer than 30 days for appointments was eliminated within 5 weeks.

Patients Waiting Longer Than 30 Days for Appointments Since March 31, 2004		
Date	CT	MRI
March 31, 2004	661	884
April 15, 2004	289	368
April 22, 2004	190	362
April 29, 2004	0	132
May 6, 2004	0	0

STAT and Urgent Exam Delays

Imaging exams requested with STAT and Urgent priorities were not always completed timely. The facility's policy, "Submission of Imaging Requests and Reports" (MCM 548-115-321), defines that STAT exams should be requested for life threatening emergencies, and Urgent exams should be requested for conditions that need attention within the same day. For the period January 1, 2004 through May 31, 2004, Imaging Service completed 2,278 STAT and Urgent exams. Of these, 1,757 exams (77 percent) took 2 or more days to complete the exam, interpret the image, and verify the results.

Interpretation and Verification Delays

Medical center radiologists did not interpret or verify a significant number of radiographic images within 5 days² of exam completion. Managers initially reported that radiologists generally interpreted and verified radiographic images within established time frames, and provided us with performance improvement reports supporting this assertion. Our review of 2,977 CT and MRI requests that were not scheduled within 30

² The 4-day performance measure went into effect in November; therefore, we used the previous 5-day measure, which covered a majority of the date range reviewed.

days during the period April 2002 through May 2004 showed that: (i) on 656 requests (22 percent), the turn-around-time from exam completion to exam verification exceeded 5 days; (ii) on 211 requests (7 percent), the exams were not verified for 2 weeks or more.

The 2,977 requests that were not scheduled within 30 days included 253 requests that were completed during the period April 15 to May 13, 2004 (the period of the performance measure data provided to us). Of the 253 requests, 81 (32 percent) took longer than 4 days to verify; in 35 (14 percent) requests, the exams were not verified for 2 weeks or more.

After our inquiries, the CIS told us that he had reviewed the Radiology Performance Improvement (PI) measure and identified numerous ways in which the data could be retrieved and analyzed. As such, data from more recent date ranges could reflect higher compliance with the performance measure because sufficient time had not elapsed to complete the cycle of exam, interpretation, and verification. The CIS forwarded a memorandum to the Medical Center Director on June 10 outlining his concerns, and the Service has adjusted the date ranges for PI measures to more accurately reflect turn-around-times.

Allegation A-2: As a result, some veterans died.

The allegation was not substantiated. Imaging Service managers and staff denied knowledge of any cases where patients were harmed by imaging delays. Our review of 17 cases where imaging exams were not scheduled for more than 30 days did not reveal any adverse patient outcomes. In February 2004, a physician referred seven cases to the Risk Manager; however, peer review of these cases did not identify any adverse outcomes. The Risk Manager also reviewed her database for adverse outcomes related to imaging delays for the period June 2003 to May 2004, but did not find any incidents attributed to delayed Imaging exams.

At our request, the Chief of Staff (COS) and CIS evaluated 62 primary lung cancer cases diagnosed between June 1 and December 31, 2003, to determine whether delays in imaging studies adversely affected the timeliness of diagnosis or treatment. While the COS and CIS did not identify any adverse outcomes, we identified a case where the patient, initially told he had lung lesions, experienced a delay in diagnosis and treatment because Imaging Service did not deliver timely service:

On June 11, 2003, a pulmonologist ordered a STAT MRI to determine if the patient's lung lesions (cancer) had metastasized (spread). The exam was not completed until June 25th, not interpreted until September 26th, and not verified until October 1st, more than 3 months after the STAT request. The interpreting radiologist recommended a follow-up exam, as he noted an abnormality requiring attention. However, the patient had moved out of state.

Had the MRI been performed and interpreted immediately, as required by community standards of care, the patient's follow-up care at his new treatment location could have been coordinated. On June 25, 2004, we notified the COS at the patient's current VA treatment location of our concerns. The patient had a lobectomy (removal of a lobe of the lung) on September 8, 2004. The pathologist reported "metastatic adenocarcinoma which extends beyond the lymph node capsule" and found "around the bronchus a moderately differentiated in situ and invasive squamous cell carcinoma." He concluded, "Many peribronchial lymph nodes are involved by the carcinoma."

The patient's care, beginning with the delayed MRI and interpretation, included multiple points where VA providers (West Palm Beach and other VA medical centers) should have aggressively followed-up on the patient's test results and presenting symptoms, but did not. Regardless of whether the lesion was cancerous and metastatic (as with this patient), or benign, to delay definitive diagnosis for 15 months in a patient with a lung lesion does not meet the standard of care.

Allegation A-3: MRIs were [inappropriately] outsourced and excessive overtime was used.

The allegation was not substantiated. Imaging Service did use outsourcing and overtime to process some MRI and CT exams; however, these actions appeared to be necessary and reasonable to process an increase in imaging workload, while eliminating the backlog in imaging requests.

As of May 2004, Imaging Service had an assigned ceiling of 60 Full-Time Equivalent employees. There were 9 vacancies, including 2 diagnostic technologists and 4 radiologists. In Fiscal Year (FY) 2003, Imaging Service completed almost 80,000 exams. In FY 2004, the Service had completed more than 76,000 exams by July 12, 2004. In FY 2003, Imaging Service received a monthly average of 6,800 imaging requests; however, through July 12, 2004, the Service was receiving a monthly average of around 8,000 requests, which was a monthly increase of about 17.6 percent (1,200 requests). Actions taken by the medical center to process this increase in workload included working extra shifts and weekends, and modifying an existing fee basis contract.

As of July 16, 2004, the medical center had outsourced 1,791 (941 MRI and 850 CT) requests at a cost of about \$445,000. During the period October 1, 2003, through May 1, 2004, Imaging Service staff worked 218 hours of overtime valued at about \$7,200 on tasks related to MRI and CT scans. This did not appear to be excessive, compared to overtime used for other tasks. During the same period, Imaging Service staff worked a total of 1,307 overtime hours valued at about \$37,800 on tasks unrelated to MRI and CT scans. In our opinion, the outsourcing and overtime work were justified and appropriate actions to decrease the waiting times for MRI and CT exams. Therefore, we did not substantiate the implied inappropriateness of these actions.

Imaging Service Managers Did Not Properly Monitor Next Available Appointments or Address Workload Issues

The Imaging Service PI Coordinator improperly excluded weekends and holidays from the medical center's performance improvement measure #42, "Outpatient Appointment Availability by Modality," which monitors the number of days to the next available appointment for routine exams. The VISN requires that routine exams be scheduled within 30 calendar days of request. The exclusion of weekends and holidays artificially decreased the number of days to the next available appointment. The PI Coordinator adjusted the monitor to accurately report the number of calendar days until the next available appointment.

In addition, Imaging Service managers did not properly track pending requests, incomplete exams, and other workload measures to ensure that patients received quality services. The Radiology computer package offers several reports that, if routinely generated, would have disclosed access and timeliness delays for some exams dating back to 2002. The "Incomplete Work" list identifies cases when certain steps in the imaging process do not meet timeliness standards, and the "Pending" list identifies cases where a request has been received in Imaging Service, but the patient has not yet been registered for an exam. Imaging Service managers stated that they did not regularly generate these reports because the Service lacked the staff to effectively follow up on pending and incomplete cases.

Conclusion

Patients were not scheduled for imaging exams in a timely manner, nor were images interpreted and verified in accordance with VHA and VISN timeliness standards. While we did not identify any cases where patients died because of imaging delays, Imaging Service did not consistently meet standards of care. We found one patient who experienced an extensive delay in diagnosis and treatment, in part due to untimely imaging services. Imaging Service managers did authorize outsourcing and overtime to keep pace with workload demands and eliminate a backlog of imaging requests. Therefore, we did not find these actions to be inappropriate or excessive. However, had Imaging Service managers properly monitored pending and incomplete workload, the backlog of requests would have been identified and addressed earlier, which might have reduced patient waiting times for MRI and CT exams.

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that: a) imaging exams are scheduled, interpreted, and verified within established timeframes; b) clinical managers complete a peer review of the identified cancer patient's care; and c) imaging Service managers utilize appropriate computer generated tracking reports to assure timely Imaging services.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plans. The medical center has implemented several improvements to include staff training, radiologist remote access, new reading stations, installation of another CT scanner, and development of new performance measures to track efficiency. Clinical managers have completed the requested peer review and are assessing ways to prevent such delays in the future. Additionally, managers are utilizing new reports to track the timeliness of reading images, and reporting and transcribing results. See pages 15-21 for the full text of the Directors' comments.

Assistant Inspectors General Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Allegation B: Wound care services to veterans were discontinued; CBOC employees were not trained properly in wound care, and; because proper wound care training had not been provided to VA-contracted CBOC providers, negligent care, diagnoses of gangrene, and amputations resulted.

Findings

The allegation was not substantiated. Patients received routine wound care services through their Primary Care and specialty providers, and Surgical Service treated patients requiring more complex wound care, such as amputations or the debridement of necrotic ulcers. Medical personnel are trained in chronic wound care as part of their medical residency or nurse training programs and, as such, wound care is an expected competency for these clinicians. Although documentation of wound care training for CBOC providers was limited, medical record review disclosed that providers were appropriately assessing and treating patients' wounds.

We reviewed the medical record in the only case referred to us and found that CBOC providers rendered appropriate care and treatment. Additionally, we identified 17 cases, for the period October 1, 2003, through March 31, 2004, where the patients' diagnoses or procedures were related to amputations. We eliminated one case from our review, as the patient had been an amputee for more than 25 years. For the 16 remaining cases, we reviewed progress notes, consultation requests, and other documents dating back to the first indication of circulatory problems. Medical record documentation disclosed proper

assessments of patients' skin color, temperature, and the presence of pulses. Consultation requests were appropriate, and wound care treatment reflected acceptable standards of care. We did not identify any instances of negligent care, or cases of gangrene and amputation, because of untrained or unskilled CBOC providers.

Allegation C: Employees were forbidden to assist homeless veterans seeking healthcare from the Emergency Room.

Findings

The allegation was not substantiated. We found no evidence that homeless veterans were denied care in the Emergency Room, also known as the Evaluation Center (EC). While the complainant did not provide us with any specific cases, our review of the EC treatment log and the patient advocate reports for October 2003 through March 2004 did not demonstrate denial of care to homeless veterans. The EC log showed that 47 patients who presented for care were categorized as either being homeless or having no address. The log showed that all 47 patients received treatment in the EC and were given follow-up appointments as indicated. The patient advocate reports did not reflect any complaints that patients were being denied care in the EC.

All managers and employees that we interviewed, including representatives from Mental Health and Behavioral Science, the Homeless Program, Social Work Service, and the EC denied any problem with homeless veterans being treated in the EC. The Physician's Assistant (PA) assigned to the Homeless Program told us that, as part of his field duties, he visits Vet Centers and homeless shelters in the evening and sends homeless veterans needing medical care to the EC. He also related that he travels with local police at least monthly to sites where homeless people congregate to briefly examine homeless veterans and then refer (or have them transported) to the EC for treatment. The Homeless Program Coordinator told us that when the PA is not on duty at the hospital, social workers, counselors, or other Homeless Program employees regularly send homeless veterans to the EC for treatment. It appears that medical center employees actively assist homeless veterans seeking healthcare.

Issue 2: Mismanagement

Allegation D: Administrative staff participated in a medical center planning retreat at the Radisson Beach Resort on Hutchinson Island, which is approximately 60 minutes from the medical center and did not require overnight travel; yet lodging was provided for all staff.

Findings

The allegation was partially substantiated. The medical center held two retreats for planning purposes in FY 2003 and FY 2004. One retreat was held during the period October 3-4, 2002, and one was held during the period November 6-7, 2003. The justification for the retreats cited the development of strategic plans. According to the Government Accountability Office, federally sponsored meetings, such as retreat conferences, are within agencies' administrative discretion. Per diem reimbursement was allowable under VA policy MP-1, Part II, Chapter 2, because the retreat was held outside the medical center's commuting area. However, the medical center deviated from VA policy regarding lodging rates and the determination of lodging sites. Our review showed that medical center staff paid \$85 per night for lodging, when the prevailing per diem rate for lodging on both occasions was \$55. In negotiating lodging rates, VA travelers are not to exceed the established lodging portion of the per diem rate by more than 25 percent. Therefore, the maximum negotiable per diem rate for lodging was only \$68.75. Additionally, cost comparisons should include, but not be limited to, a determination of adequacy of lodging rooms at the established per diem rate, which must include at least three sites. We found that medical center contract staff obtained cost data from only one lodging facility in FY 2004.

Conclusion

Although the allegation of inappropriate lodging for retreat participants was not substantiated, we found that medical center staff deviated from VA policy requirements regarding lodging rates and determination of lodging sites.

Recommended Improvement Action(s) 2. The VISN Director should require the Medical Center Director to ensure that medical center contract staff negotiates lodging rates consistent with VA policy and obtains cost comparisons from three lodging facilities, as required.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plans. The Medical Center Director agreed to ensure that lodging rates are negotiated in

accordance with VA policy, and three bids are solicited for future events. See pages 15-21 for the full text of the Directors' comments.

Assistant Inspectors General Comments

The VISN and Medical Center Directors agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

Allegation E: The facility is currently replacing its telephone system and patients may not be able to access the medical center by phone to make appointments.

Findings

The allegation was partially substantiated. On April 23, 2004, the medical center initiated a project to replace the existing Public Branch Exchange (PBX) system. The medical center Chief Information Officer (CIO) told us that inadequate management of the project by the contractor resulted in some occasions where it was difficult to contact the medical center. Specifically, the contractor's actions contributed to switch failures, which included the loss of over 400 cutover numbers, and an improperly sorted cutover sheet affecting another 320 telephones. The CIO stated that the medical center posted flyers and issued a press release to notify patients of possible problems in contacting the medical center telephonically during the installation of the PBX system. The medical center also established an emergency call center to route calls to cell phones provided to staff in clinical areas to ensure that patient care was not adversely affected during system installation. As of July 28, 2004, the deficiencies caused by the contractor have been corrected and the new system is in use. However, the medical center Chief of Operations and Telecommunications, stated that the medical center is still experiencing sporadic dropped calls because the wiring schematics for the new PBX and the carrier have not been synchronized. This is not a contractor deficiency and the medical center is currently working with the carrier to resolve the problem. While some patients may have experienced difficulty in contacting their providers, in our opinion, the medical center took reasonable steps to minimize disruptions to patient care during the replacement of the PBX system.

Issue 3: Prohibited Personnel Practices

Allegation F: Management awarded a contract in excess of \$750,000 to a personal friend of the Medical Center Director to survey employees on their opinions of management.

Findings

The allegation was not substantiated. This allegation was reported to the OIG in October 2001 and found to be unsubstantiated based on an investigation conducted by VISN 8. In essence, the Director requested a contract to develop a comprehensive Service Excellence Program that would help medical center staff focus on the quality of service provided to internal and external customers. The justification for the project was based on declining customer satisfaction scores in internal, VISN, and nationally generated surveys. In 1999, a contract to meet the needs of the medical center was awarded to Rainbow Technology, Inc., an 8A (Small Business Set-aside) contractor, by VA Central Office. According to the Contracting Officer, the Director did not have any input into the contract award process. Rainbow Technology sub-contracted with Systems, Inc. to perform the study. The cost of the contract work performed in 1999 was about \$250,000 and was paid to Rainbow Technology. In FYs 2003 and 2004, the medical center contracted directly with Systems, Inc. to conduct follow-up surveys based on the initial survey results.

Systems, Inc. was paid about \$13,000 in FY 2003, and \$14,000 in FY 2004. The complainant alleged that the on-site Technical Representative for Systems, Inc. was a personal friend of the Director. According to the Director, he met the Technical Representative during the late 1980's when she developed a Service Excellence program for the VA Medical Center in Providence, RI. The Technical Representative confirmed the Director's comments. The Technical Representative had also worked on similar projects at 13 other VA medical centers, and had performed work as a sub-contractor for Rainbow Technology on previous occasions. We found no indications of contract irregularities, or evidence of inappropriate personnel practices associated with this acquisition. Therefore, we concluded that the allegation was not substantiated.

Allegation G: An employee was promoted to a position at a higher grade after an OIG investigation found the employee was previously promoted inappropriately to an EEO Manager position.

Findings

The allegation was not substantiated. In October 2001, the OIG received a hotline complaint alleging that the medical center gave preferential treatment to an employee by promoting her to a GS-0260-9 Equal Employment Opportunity (EEO) Specialist. The

OIG substantiated the allegation and concluded that the Human Resources Management Officer committed a prohibited personnel action when he approved the promotion of the employee into the EEO Specialist position non-competitively based on accretion of duties. The employee was subsequently downgraded to a GS-0303-7 Program Support Assistant position. The EEO Manager position was announced as a GS-9 target GS-11/12, and the employee previously promoted and subsequently downgraded was selected for the manager position. We found no improper personnel action in the selection process. The announcement solicited applications from medical center employees for competitive promotion considerations. Our review of documentation obtained from Human Resource Management Service (HRMS) showed that three applicants applied for the EEO manager position, two of whom were qualified, including the employee selected. The description of duties for the EEO manager position required the incumbent to serve as the principal advisor in the area of EEO, Affirmative Employment, the Civil Rights External Programs, Alternate Dispute Resolution, and Diversity Management. The employee selected had worked full-time as an EEO Specialist from June 2001 to March 2003, gaining the necessary experience for qualification, while the other qualified applicant had only part-time experience in EEO work, which was accumulated while he was on reserve military duty. The Medical Center Associate Director selected an employee as EEO Manager based on superior qualifications. Therefore, we concluded that the allegation was not substantiated.

Allegation H: It is common practice for Service Chiefs and high-level administrators to hire family members and have them work within the same chain of command. A few examples are:

- a. Chief, Medicine Service, hired/supervises his wife who is Chief, Neurology Service.
- b. A Medical Administration Service Specialist, her daughter, and nephew all work within the same chain of supervision.

Findings

The allegation was not substantiated. The Chief, Medical Service, and his wife, the prior Chief, Neurology Service, were both hired in non-supervisory positions in September 2001. Therefore, neither was in a position to hire the other. Additionally, the wife was transferred from Neurology to Primary Care on October 6, 2002, about 2 months before her husband was promoted to Chief, Medical Service on December 15, 2002. Therefore, the Chief, Medical Service did not supervise his wife. Similarly, there was no supervisory-employee relationship between the Medical Administration Service Specialist and her daughter or nephew. HRMS does not track family members working at the medical center. However, based on last name, we identified three other groups of relatives from the COIN PAI P-59 Report (Standard Alphabetical Name Listing), and

followed up with the Service Chief and the Chief, HRMS concerning the placements for these employees. We found no employee-supervisory relationships. Therefore, we concluded that the allegation was not substantiated.

(original signed by:)

JOHN D. DAIGH, JR., MD
Assistant Inspector General
for Healthcare Inspections

(original signed by:)

MICHAEL L. STALEY
Assistant Inspector General
for Auditing

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 25, 2005
From: Network Director (10N8)
Subject: West Palm Beach OIG Draft Report
To: Director, Management Review Office (105B)

1. The VA Sunshine Healthcare Network (VISN 8) appreciates the opportunity to review and discuss the West Palm Beach OIG Draft Report.
2. VISN 8 has reviewed and concurs with the Draft OIG Report.
3. If you have any questions, please don't hesitate to contact Karen Maudlin at the VISN 8 office at (727) 319- 1063.

(original signed by:)

George H. Gray, Jr.

Attachments

Medical Center Director Comments

Department of Veterans Affairs

Memorandum

Date: November 15, 2004

From: Director, West Palm Beach VA Medical Center (548/00)

Subject: Healthcare Inspections - Patient Care and Mismanagement Issues at the VA Medical Center, West Palm Beach, Florida

To: Director, Management Review Office (105B)

Thru: Network Director (10N8)

1. The West Palm Beach Department of Veterans Affairs Medical Center respectfully submits the following information and attached documents relative to Office of Inspector General (I.G) project number 2004-02051-HI-0355.

2. It is significant to note that after inspection by the I.G. on multiple issues, the West Palm Beach VAMC was affirmed in its belief that it delivers excellent care to our nation's heroes and works assiduously every day to assure our employees and our community are proud to partner with us in our mission of "Caring for those who shall have borne the battle and their widow and their orphan."

3. In the final analysis, the Office of the Inspector General yielded two findings with recommendations relative to their investigations. As requested, discussion on those recommendations is attached

a. Issue 3: Prohibited Personnel Practices: While, this issue yielded no findings with recommendations, the report outlines the genesis of the Medical Center's Operations Excellence program. Specifically, the relationship between the Director and the contractor is discussed and subsequently was found to be both professionally and ethically appropriate. However, it is significant to note that this particular contract has been

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reviewed multiple times by both internal and external auditors. Every time the contract has been reviewed the outcome has been that the West Palm Beach VA and the Director have only engaged in activities that are in the best interest of the Medical Center. In addition, it is worth noting that the origins of Operations Excellence did occur when the Director at the West Palm Beach VAMC was employed as Director at the Providence VAMC. In fact, the Providence VAMC was one of 35 hospitals in the region that participated in this particular vendor's contract. The Director at the West Palm Beach VAMC has never had any relationship with any representative of Rainbow Technology or Systems, Inc. other than that required to fulfill the obligations of the Operations Excellence program requirements.

4. If you have any questions, or I may be of assistance in any way, please do not hesitate to contact me at (561) 422-8601.

(original signed by:)

Edward H. Seiler

Medical Center Director Comments

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that: a) Imaging exams are scheduled, interpreted, and verified within established timeframes; b) Clinical managers complete a peer review of the identified cancer patient's care; and c) Imaging Service managers utilize appropriate computer generated tracking reports to assure timely Imaging services.

Concur

Target Completion Date: April 2005

The West Palm Beach VAMC concurs with the recommended improvement action(s) 1. The WPB VAMC recognizes there were intermittent historical issues relative to processing some patient's imaging requests.

Action 1a. The West Palm Beach VAMC has taken the following steps to assure timely scheduling, interpretation, and verification of imaging studies.

(a) There has been education for Imaging Staff on process improvement-- as identified by consultant from Jackson MS VAMC, and education of providers on appropriate use of desired date when ordering studies.

(b) VPN for VA staff Radiologist home reads has been accomplished and physicians have been trained.

(c) Additional and new Reading Stations have been installed and a new reading room is being constructed to facilitate Radiologist efficiency.

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(d) Recruitment of technical and professional staff is ongoing and vacancies are being filled with temporary or agency staff.

(e) A new CT will be installed as soon as necessary construction is completed in early 2005. Our current CT will remain in place as a second scanner. In addition, purchase/lease of needed cameras and equipment is in progress. A mobile MRI is on station FT, a mobile PET/CT will be on station one day/week beginning December 2004. A new MRI has been installed and is operational.

(f) New/Modified Business Rules for processing requests were approved by Clinical Executive Board in November 2004.

(g) Safe, Effective Demand Management Systems are being developed for the most common studies.

(h) Implementation of Voice Recognition Technology is expected by FY06.

(i) Investigation of Bar Coding of requests will reduce reliance on paper requisitions and is a goal for this year.

(j) As a result of an earlier case of delayed diagnosis and treatment of lung cancer, Medical Service, Imaging Service, and the Cardiothoracic Surgery Service at Miami VA worked together on a Fast Track process for evaluation of patients with abnormal chest films suggestive of lung cancer. The result was the establishment of a Fast Track Pulmonary Clinic to expedite and evaluate patients with abnormal chest films. This program has been fully implemented

(k) Performance measures to assure efficiency with interpretation and verification have been developed and are tracked by the VISN and the facility.

Action 1a. In Summary, the above steps have considerably improved and will continue to improve the access to imaging services in scheduling, interpretation and verification. Waiting times are being tracked and reported monthly to the VISN. There were 661 patients waiting longer than 30 days in

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March of 2004 for a CT scan and there were 884 waiting for longer than 30 days for an MRI. The October report shows there are 44 patients waiting longer than 30 days for a CT scan and these are for bone density tests. Sunday CT scanning has begun to further delete this backlog. Currently MRI does not have a wait greater than 30 days. In Quarter 4 of FY 04 the performance measure was to have verification of images within 4 days. The satisfactory target for the VHA was 70% and the exceptional target was 80% of reports verified within 4 days. West Palm Beach VAMC had 90.4% verification within 4 days, surpassing the exceptional target. Target Completion Date: Active and Ongoing.

Action 1b. Peer Review Case M7020

Analysis of the care provided to patient M7020: An extensive case review was conducted and concluded that although the patient's diagnosis was made in an appropriate timeframe, this elderly man experienced a two year delay between identification of a LUL lung mass and LUL resection for lung cancer. Because of the medical complexity of the patient's condition his workup at WPB VAMC where the lesion was discovered took ten months, at which time, further studies were under consideration. He was then lost to follow up, although it appears that calls were made to his former home, and a letter was sent when he could not be located after the performance of an abnormal MRI study of the adrenals, unrelated to his primary diagnosis.

He was then followed at two VA outpatient clinics in another state. His workup was re-started, about 18 months after the LUL lesion was identified, at the request of a member of the Office of the Inspector General. This culminated in his undergoing successful resection of the lung mass, which was apparently still resectable two years after it was discovered.

West Palm Beach VA Medical Center is reviewing the sequence of events in this case to determine ways to prevent such delays from occurring in the future. Formal peer reviews are being conducted on the following disciplines: Oncologist, Pulmonologist, Primary Care Provider, & Cardiothoracic Surgeon. Target Completion Date: April 2005

Medical Center Director Comments

Action 1c. New reports are now in use to track timeliness of reading, reporting, and transcribing. In order to capture the status of all exam types, four different reports (Pending, Hold, Log of Scheduled Exams and Incomplete Exam) are being monitored daily and Lead Techs are tracking outliers to appropriate resolution. Target Completion Date: Active and Ongoing.

Recommended Improvement Action(s) 2. The VISN Director should require the Medical Center Director to ensure that medical center contract staff negotiates lodging rates consistent with VA policy, and obtains cost comparisons from three lodging facilities, as required.

Concur

Target Completion Date: Ongoing

The Medical Center will negotiate lodging rates consistent with VA policy and obtain cost comparisons from three lodging facilities as required.

OIG Contact and Staff Acknowledgments

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